SECTION 9
CUSTOM-MADE ITEMS

Medicaid payment may be made for custom-made items such as orthotics, prosthetics, custom wheelchairs and custom HCY equipment when the patient becomes ineligible (either through complete loss of Medicaid eligibility or change of assistance category to one which the particular service is *not* covered) or dies after the item is ordered or fabricated and *prior* to the date of delivery or placement of the item.

The following prerequisites apply to all such payments:

- The patient must have been eligible when the service was first initiated (and following receipt of an approved prior authorization (PA) request if required) and at the time of any subsequent service, preparatory and prior to the actual ordering or fabrication of the device or item;
- The custom-made device or item *must* have been fitted and fabricated to the specific medical needs of the user in such a manner so as to preclude its use for a medical purpose by any other individual;
- The custom-made device or item must have been delivered or placed if the patient is living; and,
- The provider must have entered "See Attachment" in field #19 of the claim form and must have attached a provider signed statement to the claim. The statement must explain the circumstances and include the date of actual delivery or placement for a living patient or the date of death when delivery or placement is not possible due to this reason. The statement *must* also include the total amount of salvage value, which the provider estimates is represented in cases where delivery or placement is not possible.

Payment of Custom-Made Items and Devices

A. If the item is received by the patient following loss of Medicaid eligibility or eligibility for the service, the payment is the lesser of the "net billed charge" or the Medicaid maximum allowable for the total service.
B. If the item cannot be delivered or placed due to death of the patient, the payment is the lesser of the "net billed charge" or the Medicaid maximum allowable for the total service. The "net billed charge" is the provider's usual and customary billed charge(s) as reduced by any salvage value amount.

- ✓ Salvage value exists whenever there is further profitable use that can be made by the provider of materials or components of the device or item. A custom-made wheelchair is an example of an item whose components represent a salvage value. The salvage value must be clearly documented in the patient's medical record.

- ✓ Any provider determined retail salvage of the unplaced, or undelivered item must be subtracted by the provider from the billed charge for the item or device and only the net reduced charge entered on the claim form. These items are subject to review for salvage value adjustments represented in the billed charge.

C. The date of service shown on the claim form for the item or device when situation A or B applies must be the last date on which service is provided to the eligible patient (and following receipt of an approved PA request if required) prior to the ordering or fabrication of the item. The provider is responsible for verifying patient eligibility each time a service is provided. Use of a date for which the patient is no longer eligible for Medicaid coverage of the service results in a denial of the claim. The claim (with attachment) is to be submitted to Infocrossing at P.O. Box 5600, Jefferson City, MO, 65102 as all other paper claims.

Payments made as described in A or B constitute the allowable Medicaid payment for the service, no further collection from the patient or other persons is permitted.

If the provider determines the patient lost eligibility after the service was first initiated and before the custom-made item is actually ordered or fabricated, the patient must be immediately advised completion of the work, and delivery or placement of the item is not covered by Medicaid. It then becomes the patient's choice whether to request completion of the work on a private payment basis. If the patient's death is the reason for loss of eligibility, the provider can, of course, proceed no further and there is no claim for the non-provided item of service.

If a patient refuses to accept the item/service, Missouri Medicaid does not reimburse the provider. The custom-made policy can be found in section 13.15 of the MO Medicaid DME manual.